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Austerity, Welfare Reform and the English Health Divide

In this commentary we argue that spatial inequalities in health will increase in England as a result of the entwined policies of austerity and welfare reform. We describe the health divide and outline the actual and potential effects of austerity and welfare reform on it by drawing on current data and previous international research. Drawing on our involvement in the 2014 *Due North: Independent Inquiry into Health Equity North*, we suggest alternative policies that could reduce the divide, or at the least, stop it from widening further. We conclude by outlining ways in which geographers can engage with this prescient issue.

The English Health Divide

Northern England (commonly defined as the North East, North West and Yorkshire and Humber regions) has persistently had higher all-cause mortality rates than the South of England, with people in the North consistently found to be less healthy than those in the South - across all social classes and amongst men and women (Dorling 2010). Since 1965, this has amounted to 1.5 million excess premature deaths (CLES 2014). Although England is not alone in experiencing such spatial health inequalities, they are some of the largest in Europe – greater, for example, than those between the former East and West of Germany (Bambra et al 2014). The reasons for the contemporary divide are both compositional and contextual, although largely seen to be socio-economic in nature. Over the past 20 years, as a result of deindustrialisation, the North has consistently had lower employment rates – of at least 10 percentage points - than the South for both men and women (ONS 2012). Welfare receipt and poverty rates are also 5 percentage points higher in the Northern regions (

Northern Austerity Pains

These chronic spatial inequalities are now being exposed to austerity - manifested as large scale cuts to central and local government budgets, as well as an NHS funding freeze and cuts to welfare services and benefits. The financial impact of this policy context varies spatially, disproportionately impacting on the older industrial areas in the North whilst the South (outside London) escapes comparatively lightly (Beatty and Fothergill 2014). By way of example, Blackpool (North West), will

experience an estimated loss, as a result of welfare reforms, of more than £900 a year per working age adult. Local government spending has also fallen by around a third since 2008 and the worst-hit local authority areas – mainly located in the North (e.g. Middlesbrough, North East - £470 less per working age adult) – have lost far more than the authorities least affected by the cuts – located exclusively in the South (e.g. Hart, Hampshire - £50 per working age adult).

Austerity and Geographical Inequalities in Health

There has not yet been a comprehensive empirical assessment of the effects of the current programme of austerity and welfare reform on spatial inequalities in health (as many of the consequences for health may not be apparent for many years, Pearce 2013). However, geography has begun to engage with the issue and what it might mean for spatial inequalities in health in *theory*, with, Pearce (2013) suggesting four pathways linking austerity and health inequalities: (1) changing social geographies in respect to the spatially unequal effects of austerity on the social determinants of health; (2) selective migration and reduced socio-spatial mobility as labour markets contract; (3) geographical changes in environmental justice particularly in terms of local service context; and (4) the exacerbation of place-based stigma and area marginalisation. In this commentary, we expand on this work by showing what it means in *practice*, highlighting the early empirical indications that austerity *is* increasing spatial inequalities in health with a particular focus on the English health divide. We also draw on previous international work on the effects of welfare reform on spatial health inequalities to support this proposition.

Since 2007, suicide rates have increased across England – but at a greater rate in the North than the South: by 2012 they were 12.4 per 100,000 in the North West compared to 8.7 per 100,000 in London (ONS 2014). Similarly, antidepressant prescription rates have risen since 2007, again with the highest increases in the North: by 2012, antidepressant prescription rates were highest in Blackpool (331 per 1,000) and lowest in Brent (71 per 1,000) (Spence et al. 2014). Food bank use and malnutrition rates have also increased more in the North (Trussell Trust, 2013). Recent data has also shown that there have been significant improvements in mortality rates amongst lower socio-economic status women in the South (East, London and South East regions) but not in Northern regions – where they have actually increased since 2002/3 (ONS, 2015). Spatially concentrated increases in unemployment over

recent years have also led to an increase in the North South divide for both morbidity and mortality (Moller et al, 2013).

Previous international research into the effects of welfare reform also suggests that existing spatial inequalities in health will increase. This is evident, for example, in studies of New Zealand in the 1980s and 1990s when major welfare reform (including: a less redistributive tax system, a targeted social benefits, regressive tax on consumption introduced, privatisation of major utilities and public housing, user charges for welfare services, and a more deregulated labour market) resulted in a rapid increase in spatial inequalities in health (Pearce and Dorling 2006; Pearce et al. 2006). Since the mid-1990s, when the New Zealand economy improved and there were some improvements in services (e.g. better access to social housing, more generous social assistance and a decrease in health care costs), regional inequalities stabilised (Pearce and Dorling 2006). Similarly, in the UK during the Thatcher governments (1979-1990), when restrictions to benefit entitlement, value and coverage were implemented, the North and Scotland fell behind the rest of the UK in terms of improvements in life expectancy (Scott-Samuel et al. 2014).

Together, these early signs and previous international experience, suggest that the health effects of austerity and welfare reform will have differential spatial effects: the North of England – with its higher rates of poverty, unemployment and welfare receipt - will suffer disproportionately. This is potentially also the case in other austerity-stricken countries where peripheral or marginalised areas may lose out most. In England, austerity will only serve to increase the health divide further – unless something changes.

A Northern Way?

So, what can be done to prevent austerity and welfare reform increasing spatial inequalities in health? This was one of the questions addressed by the Public Health England (PHE) commissioned *Due North: The Independent Inquiry into Health Equity in the North* (CLES 2014). The report examined what national and local government and the voluntary sector could do to reduce health inequalities *between* the North and the rest of England (as well as decreasing inequalities *within* the Northern regions). In our background paper commissioned by the Inquiry on the role of welfare reform and

austerity in shaping the English health divide (Authors 2014), we suggested the following evidence-based interventions: (a) increasing the value of welfare benefits; (b) improving welfare rights advice services; (c) making work pay by introducing a living wage; (d) implementing health-first active labour market policies to tackle health-related worklessness; and (e) decreasing debt by capping loan rates, supporting credit unions and regulating energy companies. These recommendations address three of the four pathways linking austerity and spatial inequalities in health identified by Pearce (2013) – social geography; environmental justice and area marginalisation, and as such, they could reduce the English health divide, or at the least, stop it from widening further. These suggestions are also relevant beyond the English case where other countries are experiencing the ill health effects of austerity (Stuckler and Basu 2013).

Conclusion: A geographical moment?

Partly as a result of the *Due North Inquiry*, and partly as an outcome of renewed debates about English devolution, there is now a “policy window” around the English health divide. This represents a prime opportunity for geographers to influence this important area of research, policy and practice. As with work on the Scottish and Glasgow health effects, we can lead research into the effects of austerity and welfare reform on the English health divide – and spatial inequalities in health in general and not just in England - by, for example, longitudinally examining the localised health effects of austerity and welfare reform or empirically exploring the posited pathways between austerity and spatial inequalities in health. The recommendations from the *Due North* report could also form the basis for future geographical research – both nationally and internationally - that engages with and critically analyses health inequalities post-welfare reform. Vitally though, we should also be involved in identifying - *and advocating for* - solutions that reduce spatial inequalities in health by improving the context in which *all* people live, work and play.

1455 words

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